TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John D. Kirkwood, D.O.

Respondent Name
Service Lloyds Insurance Company

MFDR Tracking Number
M4-16-1061-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Review of the submitted documentation finds that the doctor performed an evaluation of Maximum Medical Improvement and Impairment Rating for two **(2) body areas** – one (1) musculoskeletal body areas with range of motion **ROM** *lower extremities* right Foot, two (2) non- musculoskeletal body area with diagnosis related estimate DRE *body structures (including skin)* Scaring right Thigh. For total allowable of $800.00. The insurance carrier paid $650.00; I am requesting reimbursement for an additional $150.00, for a total reimbursement of $800.00."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent (Co0rvel) disagrees with the Requestor's stance. The diagnosis for the foot injury was a *burn of unspecified degree of foot (945.02).* This represents a non-musculoskeletal area (skin)…

Further, the diagnosis for the thigh, *scar condition and fibrosis of skin (709.2)*, is also non-musculoskeletal as defined in rule 134.204(j)(4)(D)(1)…

As IR was performed on two non-musculoskeletal body areas, the original reimbursement is correct…

It should also be noted, the Requestor was not asked to address a scar on the injured worker's thigh as this is not part of the compensable injury. As such, even if the burn is considered musculoskeletal, the maximum reimbursement would be $300 for one body area as the thigh should not have been addressed."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement and Impairment Rating	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj
   - ORC – See Additional Information
   - Notes: "MMI/IR AT ROM METHOD FOR ONE AREA"
   - Notes: "MMI/IR ROM 1 AREA. Thigh and Foot are both considered the LOWER EXTREMITIES WHICH ACCOUNT FOR 1 AREA. NO ADDITIONAL REIMBURSEMENT ALLOWED."

Issues

1. Does a relatedness issue exist for this dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. On their position statement, the insurance carrier stated that reimbursement is not owed for the impairment rating of the thigh because, "it is not part of the compensable injury." 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…"

   Review of the submitted documentation does not find that this issue was among the denial reasons presented to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and,
   (III) lower extremities (including feet).
   (ii) The MAR for musculoskeletal body areas shall be as follows…
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area; …
   (D) …
   (i) Non-musculoskeletal body areas are defined as follows:
   (I) body systems;
   (II) body structures (including skin); and,
   (III) mental and behavioral disorders…
   (v) MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right foot. Therefore, the correct MAR for this examination is $300.00.

Review of the submitted documentation also finds that the requestor performed an impairment rating evaluation of scarring of the right thigh. As a non-musculoskeletal impairment, the correct MAR for this examination is $150.00.

3. The total MAR for the disputed services is $800.00. The insurance carrier paid $650.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.